OUTPATIENT DISCHARGE FORM

Please complete and submit this Discharge Form for your ValueOptions patient as soon as you confirm a Discharge Date. For example, if this is an unplanned, patient-directed discharge, submit this form as soon as you are aware of the fact that your patient has discontinued using your services.

Actual Discharge Date: ____/____/____

Type of Service: ❑ Mental Health ❑ Substance Abuse

Patient Name: _____
Date of Birth: _____ Age: _____ ❑ M ❑ F
Address (City/State only): _____Tel #:_____
Patient's Insurance ID#: _____
Patient's Employer/Benefit Plan: _____

Provider Name: _____License: _____
Provider Program/Clinic (if applicable): _____
VO Provider # (if known): _____
Service Address: _____ Tel #: _____
City/State/Zip: _____
Licensure level (type of license): _____
Are you independently licensed to provide services in the State where you are treating this patient? ❑ Yes ❑ No
ID #: _____ *Check Which*: ❑ SSN ❑ Tax ID ❑ NPI

Primary Discharge DSM-IV Diagnosis: _____

Discharge Condition: ❑ Improved ❑ No Change ❑ Worse ❑Unknown

Type of Discharge: ❑ Planned ❑ Unplanned

Discharge Reasons: (*Check all that apply*)
❑ No further treatment indicated/stable
❑ Chose to disengage at this time
❑ Medication Management follow-up only
❑ Required more intensive services
❑ Chose other outpatient provider/service
❑ No longer eligible
❑ Moved
❑ Unable to contact
❑ Other: _____

Current Risk Assessment:
Scale:: 0 = none 1 = mild, ideation only
2 = moderate, ideation with EITHER plan or history of attempts
3 = severe, ideation AND plan, with either intent or means
na = not assessed
(Please select/circle one value for each type of risk)

Patient's risk to self:	0	1	2	3	na	With:	❑ Ideation	❑ Intent	❑ Plan ❑ Means
Patient's risk to others:	0	1	2	3	na	With:	❑ Ideation	❑ Intent	❑ Plan ❑ Means

Current Impairments: *(Please select/circle one value for each type of impairment)*
Scale: 0=none 1=mild/mildly incapacitating 2=moderate/moderately incapacitating
3=severe or severely incapacitating na=not assessed

Mood Disturbance (Depression or Mania)	0	1	2	3	na
Anxiety	0	1	2	3	na
Psychosis/Hallucinations/Delusions	0	1	2	3	na
Thinking/Cognition/Memory/Concentration Problems	0	1	2	3	na
Impulsive/Reckless/Aggressive Behavior	0	1	2	3	na
Activities of Daily Living Problems	0	1	2	3	na
Weight Change Associated with a Behavioral Diagnosis	0	1	2	3	na
Medical/Physical Condition	0	1	2	3	na
Substance Abuse/Dependence	0	1	2	3	na
Job/School Performance Problems	0	1	2	3	na
Social/Relationship/Marital/Family Problems	0	1	2	3	na
Legal Problems	0	1	2	3	na

Treating Provider's Signature: _____

Date: _____